Local Health Department Finance & Billing Principles

Presented by DHHS/DPH/LTAT Public Health Administrative Consultants

Ann Moore

Dianne Edwards

Kathy Brooks

Jessica Garner

Sandy Tedder

Consolidated Agreement & Agreement Addenda

Presented by Jessica Garner
Public Health Administrative Consultant
DHHS/DPH/LTAT

Consolidated Agreement

- Contract between Local Health Department & DPH
- Outlines requirements for Local Health Departments and NC Division of Public Health
- It applies to all activities related to DHHS funding reimbursed through the WIRM
- Revised and Renewed Annually

http://publichealth.nc.gov/lhd/docs/CA-Final-FY17.pdf

Consolidated Agreement Con't

- Amendments and Termination of the Agreement
- Amendments, modifications, termination or waivers
 - Can be made at any time by mutual consent of all parties.
 - Need to be in writing and signed by appropriate authorities
 - Either party may terminate this agreement upon sixty (60) days written notice
 - If termination occurs, the health department will receive payment only for allowable expenditures

Consolidated Agreement Con't

- Responsibilities of Department/ Local Public Health Unit
- Funding Stipulations
- Fiscal Control
- Personnel Policies
- Confidentiality
- Civil Rights
- Responsibilities of the State
- Disbursement of Funds
- Amendment of Agreement
- Provision of Termination
- Compliance

Responsibilities of the LHD

- Perform activities in compliance with applicable program rules contained in the North Carolina Administrative Code, as well as all applicable Federal and State laws and regulations.
- Perform the activities specified in the Program Agreement Addenda
- Report client, service, encounter, and other data as specified by applicable program rules VIA HIS!!!
- Enforce all rules adopted by the Commission for Public Health (GS 130A-29)
 - http://www.ncga.state.nc.us/enactedlegislation/statutes/ html/bychapter/chapter_130a.html
- Provide formal training for Governing Boards
 - Notify LTAT Branch (Phyllis Rocco) who will be providing the training by April 30)

Funding Stipulations

- Funding is subject to the availability of State, Federal, and Special Funds
- State, Federal or Special Project funds shall not be used to reduce locally appropriated funds (no supplanting)
- Health department must maintain employee time records based on actual time worked in the activity
- Provider Participation Agreement with Division of Medical Assistance must be executed
- Establish one charge/fee for all payors (including Medicaid) based on related costs
- No one shall be refused services because of an inability to pay

Funding Stipulations Con't

- Equipment/Inventory/Fixed Assets
- Equipment must be accounted for in accordance with the NC state treasurer's policy manual (chapter 20)
- The WIC program has separate inventory requirements (see your agency's WIC program manual)

Reimbursement for Public Health Training

- "Introduction to Principles and Practices of Public Heath & Public Health Nursing" (\$400.00)
- "Management and Supervisor for Public Health Professionals" (\$625.00)
- Reimbursement requests must be filed by LHD within one year of completion
- See Attachment C in the consolidated agreement
- Environmental Health Trainings
- CIT Intern Trainings
- Cross Training for REHS
 - See page 7 item 15 in the consolidated agreement

Fiscal Control

- Health Department shall retain copies of the following budget & expenditure reports:
- All Funding Authorizations
- Monthly certified electronic printed screen of the Expenditure Reports with any amendments via WIRM
- Consolidated Agreement
- Agreement Addenda
- Revisions and other financial records as required by the Records Disposition Schedule
 - http://archives.ncdcr.gov/Portals/3/PDF/schedules/Local%20Schedules/Local_Health_Departmens_20070907t.pdf?ver=2016-03-11-084038-573

Fiscal Control Con't

- The Department shall observe the following conditions when budgeting and reporting revenues:
- Locally appropriated funds may not be supplanted by revenues from persons, or public or private third party payors-
 - Which means that you can't use revenue to offset the amount of local dollars that have been budgeted.
- Revenue earned must be used for the activity that generated the revenue with the exception of WCH programs (FP and MH only at this time)

Audit Requirements

- The Department shall have an annual audit performed in accordance with "The Single Audit Act of 1984 and OMB Circular A-133
- All District Health Departments and Public Health Authorities must complete quarterly a Fiscal Monitoring Report

Personnel Policies

- Must adhere to state personnel policies related to:
 - Equal employment opportunity
 - Affirmative action
 - Local classification and salary range
 - Recruitment and Retention
- NC G.S. 126

http://mobile.ncleg.net/EnactedLegislation/Statutes/PDF/ByChapter/Chapter_126.pdf

Personnel

http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20j/10a% 20ncac%2013j%20.1003.pdf

Confidentiality

- All information regarding provision of services or other activity under this agreement shall be privileged and be held confidential
- Information cannot be released without proper consent
- All employees must sign confidentiality statements

Civil Rights

- Interpreter services must be provided at no charge to Limited English Proficiency clients for all programs and services supported by federal funds. Must have policies & procedures that comply with:
- Title VI of the Civil Rights Act of 1964;
- Section 504 of the Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972;
- Age Discrimination Act of 1975
- American with Disabilities Act 1990

Responsibilities of the State

- Provide training and technical assistance:
- Management Teams/Staffing
- Policy Development
- Program Planning and Implementation
- Quality/Performance Improvement
- General Administrative Consultation
- Board Relations
- Problem Solving

Responsibilities of the State

- Provide "Estimates of Funding Allocations" no later than Feb 15th
- Provide a "Funding Authorization" to the Department after the receipt of the Certified State Budget
- Provide a final Budget Form after receipt of the Certified State Budget
- Assist with compliance related to all applicable laws, regulations, and standards relating to the activities covered in this agreement
- Be assured that the Department maintains expenditures of locally appropriated funds (MOE)
 - This amount is provided to the Department for use in budget preparation.

Disbursement of Funds

- The State will disburse funds on a monthly basis; monthly disbursements for each program activity will be based on monthly expenditures reported (in the WIRM)
- You will not receive payment if expenditure reports are not received by the specified time (based on the Controller's office schedule)
- Total payment by program activity is limited to the total amount of the "Funding Authorization" and any revisions
- Final payments for the FY will be made based on the Final monthly (May services/ submitted in June Report) Expenditure Report

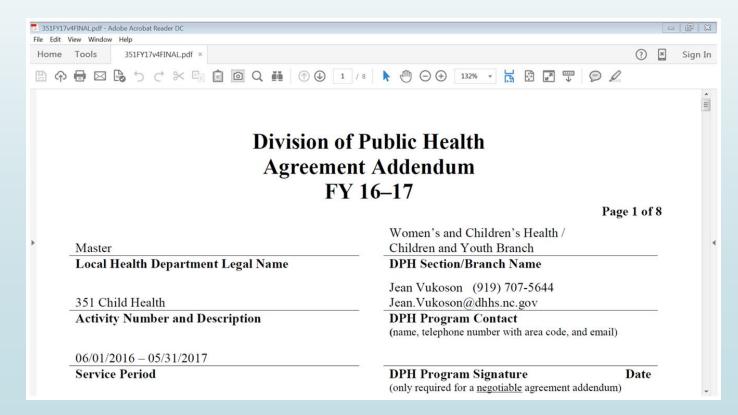
Compliance

- The State shall respond to non-compliance with all terms of this agreement as follows:
- The State shall give the Department 60 days written notice to comply
- ■If deficiencies are corrected, department must submit a written corrective action plan
- ■If deficiencies are not corrected, funds may be temporarily suspended pending negotiation of corrective action plan
- ■If deficiencies are not corrected within 30 days, funds may be permanently suspended
- Department may be declared ineligible for further State contracts or agreements

Agreement Addenda

Agreement Addenda Con't

- Provides program specific requirements for each state funded activity
- Guides the clinical and support services through the best practices of care, as well as the legal requirements of staffing, quality and quantity of services.



Agreement Addenda Con't



It is important that the Health Director use Blue Ink as noted here

Health Director Signature	(use blue ink)	Date
Local Health Department to complete: (If follow up information is needed by DPH)		LHD program contact name: Phone number with area code: Email address:

Signature on this page signifies you have read and accepted all pages of this document.

Revised 8/8/12

Scope of Work and Deliverables

Scope of Work and Deliverables:

The Family Planning program has a negotiable Agreement Addendum. Please complete Sections A and B along with the appropriate worksheets (attached). Attachment A and Attachment B worksheets, if needed **must** be returned with the signature page (page 1). Women's Health Branch (WHB) staff will review and approve.

Section A: Non-Medicaid Services (Attachment A)

The Health Department will provide Non-Medicaid Service Deliverables in FY14 that meet or exceed the total dollar value of all services budgeted. Health Information System (HIS) service data as of August 31, 2014 will provide the documentation.

Instructions: Using Attachment A worksheet, local agencies must use the reimbursement rates for each service type in estimating the total cost of Section A deliverables.

Section B: Other Program Services (Attachment B)

If the total estimated cost of Section A is less than the total amount of Department of Health and Human Services (DHHS) funds budgeted in the budgetary estimates in the DPH Aid to County Database (WIRM), additional information must be provided on how the local agency will use the remaining DHHS funds to further the program's goals and objectives. In Attachment B, list only activities that are not Medicaid reimbursable and not part of the cost of the service deliverables in Section A. No physician time can be billed except for clinical visits that are not reimbursed by Medicaid. The total estimated cost of all Section A and Section B deliverables must equal or exceed the total DHHS funds budgeted.

Instructions: See Attachment B; Section B, Other Program Deliverables for suggestions of allowable areas of expenditures for this Section. Please return this worksheet with your signed Agreement Addendum, only if Section B/Other Program Deliverables are being used.

Total Family Planning Budget (Attachment A amount + Attachment B amount)

Total Amount \$

Amount S

Amount S

Please return to DPH:

- Signature page (page 1)
- Page 2
- Attachment B, if necessary (page 14)
- Attachment C (page 16)

In Summary

- Be certain to send your completed Agreement Addenda in on time-typically noted in the cover letter that comes with the packet
- Review and retain copies of all Agreement Addenda- this is your fiscal guide for the year and contains requirements for drawing down funds
- Ensure that appropriate clinical staff have this information (program coordinators/ DON/etc). Guideline for provision of services and outcomes.

QUESTIONS

Budget Preparation Maintenance of Effort Business Reports

Presented by Ann Moore
Public Health Administrative Consultant
DHHS DPH LTAT

Training Objectives

- Review Budget Preparation Process
 - Discuss Budgeting Requirements
 - Discuss Expenditures and Projections
 - Discuss Funding Streams and Projections
 - Review Maintenance of Effort Requirements
- Suggestions for Business Measurement Reports
- Suggestions for Increasing Revenues and Decreasing Costs
- Suggestions for Creating a budget Notebook

NCGS 159 Local Government Finance

- NCGS 159-8 (a)
 - Each local government and public authority shall operate under an annual balanced budget ordinance adopted and administered in accordance with this article.
- ► NCGS 159-8 (b)
 - The budget ordinance of a unit of local government shall cover a fiscal year beginning July 1 and ending June 30.

Different County Budget Types



One county
health
department
budget
regardless of
the number of
program
budgets



Two or more program budgets within one county budget



One county budget per program budget

Budget Preparation

Expenditures Equal Revenues

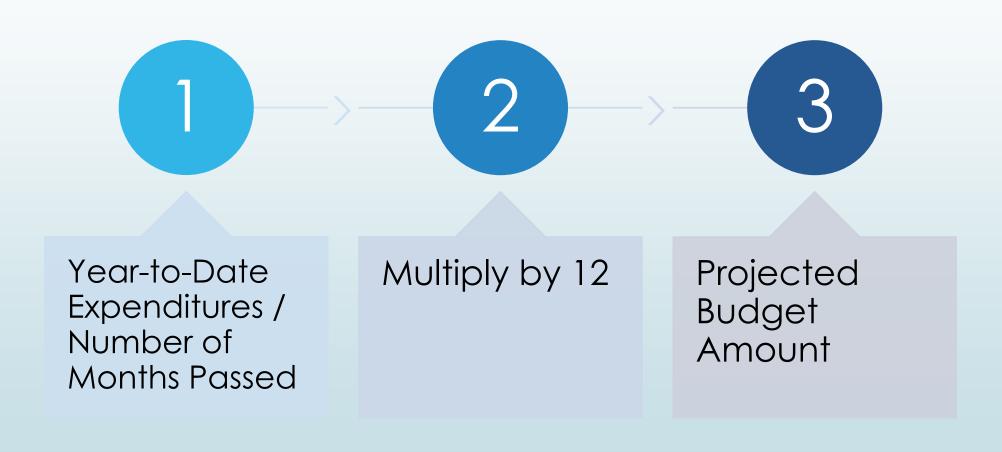
Health Department Expenditures

- Salaries and Fringe Benefits
 - Include Training Expenses if Hiring New Staff
- Operating expenses
 - Vendor Contracts
 - Anticipate Increased Costs
- Capital Outlay
 - Prior Approval required if cost exceeds \$2500
 - ►For PHP&R \$2500 per invoice
 - WIC has special requirements

Administrative Overhead

- Most DHHS grants reimburse Administrative Overhead Costs
- Some DHHS grants limit by percentage and/or other method
- Still BUDGET overhead expenses if appropriate
 - Use funding source other than program funds

Budget Calculations



Health Department Revenues

- State/Federal grant dollars
- Local appropriations
- Medicaid earnings
- Other receipts
 - ► Fees (Self Pay Patients, Companies, etc.)
 - Third-party billings (insurance, Medicare, etc.)
 - Grants (Kate B. Reynolds, March of Dimes, etc.)
 - Contracts, Donations

State Funding

- Includes State Grants and Federal Grants
- Allocated Annually
- Refer to your Agreement Addendum
 - Required Work Activity
 - Funding Stipulations
 - Prior Approval for Purchases
 - ► Limitation on monthly draw down amount
 - Draw down by method other than expenditures

Medicaid Earnings (102)

- Consolidated Agreement C.4.g
 - ► Must equal or exceed revenues earned during FY 2015-2016
 - Budgeted amounts less than revenues earned during FY 2015-2016 must be justified
- Ensure that denials are rebilled promptly
- Medicaid Cost Settlement
- Single County Health Departments are responsible for providing County Finance with details for posting Medicaid payments

Other Revenues (103)

- Medicare and Other Insurance
- Self Pay Patient Fees
- Company Billing or Other Contracts
- Other Grants
- Donations

Insurance Revenues

- Pursue credentialing with insurance carriers
- CAQH standard credentialing application
- Ensure that denials are rebilled promptly

Self Pay Patient Fees

- Highest probability of collection is while patient is onsite for visit
- Patient Statements should be mailed monthly
- Payment Agreements are effective <u>IF</u> someone follows up
- Utilize NC Debt Setoff
- Family Planning allows required proof of income
- Reminder all WCH charges must slide

Medicaid, Insurance, and Self Pay

- Consolidated Agreement C.4.b.
 - Revenue Spent in Program where it was Earned
 - ■WCH revenues can be spent in any WCH program unless specific Agreement Addendum has more restrictive requirement
- Consolidated Agreement C.4.c.
 - Unspent Revenue Carries Forward
- Consolidated Agreement C.4.f.
 - ► Funds carried forward should be spent in program where earned

Other Revenue Sources

- Company Contracts
- **■** Grants
 - ► Kate B. Reynolds
 - March of Dimes
 - **■** Local Grants
- Donations
 - **■** Patients
 - **■** Businesses

Local Appropriations (101)

- Consolidated Agreement B.2.
 - May not be supplanted
- Consolidated Agreement C.4.a.
 - May not be supplanted
- Consolidated Agreement A.17.
 - Maintenance of Effort (MOE) is maintained for Maternal Health, Child Health, and Family Planning
 - ► Equal to or Greater than July 1, 1984 June 30, 1985
 - Adjusted by federally accepted inflation index
 - ■Attachment B

MOE Form – Local Use Only

	Division of Public Health													
Local Health Department Staff Time/Activity Report														
		for Fiscal Year Ended May 30, 20XX												
	Local Health Dept:													
			FA3	101	ro1	rp.								
			[A]	[B]	[C]	[D]								
		DDU	Total	Salary/Fringe	Salary/Fringe	A-(B+C)=D								
		DPH	Staff Time	Expenditures	Expenditures	Local Staff Time								
	_	Contract	(Salary/Fringe)	Reimbursable	Reimbursable	(Salary/Fringe)								
	Program	Number	in this Program	by DPH	by Other Grants *	in this Program								
	Child Health					\$ -								
	Maternal Health					\$ -								
	Family Planning					\$ -								
	, ,													
					Total:	\$ -	**							
	* Other grants refer to	non-DPH gran	ts from other governm	ental agencies or pri	ivate foundations.									
	**This amount will be	compared to the	e "TOTAL" amount ente	ered for Fiscal Year	1984-1985 to determine	e compliance								
	with the local mainte	enance of effort	requirement of Chapte	er 479, Section 99 o	f the 1985 Sessiion Lav	vs.								
	CERTIFICATION:	The above info	rmation is accurate to	the best of our know	ledge and belief and ha	s been derived								
		from the emplo	yee time and financial	records of the Healt	h Department.									
	CONTRACTOR SIGN	ATI IRES:												
	CONTINUE TON SIGN	TOILO.	Health Director		Finance Officer									

Tracking Reports

- Monitor budgets throughout the year and amend as needed
- Ensure that you stay within your budget throughout the year
- Ensure that all chargeable expenses are coded to the appropriate program
- Ensure that billing is current
- Monitor Program Profit/(Loss)

Agency Reports and Considerations for Health Directors



Revenue Spreadsheets

- Revenue Earned Should be Separated by Program and then by Pay Source
- Track each Revenue Source Separately
 - Budgeted Amount
 - Year to Date Revenue
 - Percentage Received
- Total Revenues by Program
- Reconcile with County Finance General Ledger
- Review Monthly during last half of fiscal year

Tracking Revenue is Important

Planning

Budget Planning for Next Fiscal Year

Reviewing

Determine if
Current
Budgeting
Expectations are
Met

Monitoring

Billing Activity

- Are encounters up to date?
- Are denials corrected and resubmitted?
- Are bills created and mailed?
- Are all allowable services billed?

Expenditure Spreadsheets

- Track the status of each expenditure line
 - Budgeted Amount
 - Year to Date Expenditure
 - Percentage Spent
- Tracks total expenditures by Program
- Review Monthly during last half of fiscal year
- Review County Finance Detail General Ledger Monthly

Tracking Expenditures is Important

Planning

Budget Planning for Next Fiscal Year

Reviewing

Determine if
Current
Budgeting
Expectations are
Met

Monitoring

Ensures that Bills are Paid Timely

Profit/(Loss) Reports



Separated by Program

2

Compare Revenue to Expenditures

3

Will Determine Each Program's Profit/(Loss)

Performance Reports



Practice Management Financial Worksheet

2

Practice Management Clinical Worksheet

QUESTIONS

Time Equivalencies & WIRM Expenditure Report

Presented by Sandy Tedder,

Public Health Administrative Consultant

DHHS/DPH/LTAT

Time Equivalencies

Time Sheet/Time Study

- Determines cost of salary and fringe for each activity/program
- Needed to complete Expenditure Report in WIRM
- Required by Consolidated Agreement

Consolidated Agreement B.6

- Signed employee time records
- Actual work activity
- Daily basis
- Computed at least monthly
- Charged to Federal and State grants

Reminders

- Include every activity on time study
- Enter time as it was actually worked
- Employee should complete, sign, and date
- Supervisor signature and date required
- Make any corrections with strikethrough and initials

Time Equivalency

- Employee's salary and fringe comes from county payroll register
- Hours worked in each program is converted to percentages
- Salary/Fringe expense is re-calculated for each program based on time sheets
- Total Salary/Fringe from County Expenditure Report should equal Total Salary/Fringe on Time Equivalency

Example of a Time Study

CATEGORY - DATE 1								_ POS	MOITIE	l:							MON	ITH/Y	EAR	June	201	3		Т	IME :	STUD	Y SH	EET
	1 2	3	1 4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	1 20	29
Administration	-		1	-	-	-	-	-	10		12	15	1-4	10	10	17	10	19	20	21	- 22	23	24	25	20	21	20	29
Quality Assurance	$\overline{}$		_	_												-											_	+
Vital Records	\rightarrow	_	_	_												_											_	_
Animal Control																								_	_			_
Environ, Health		_	-																									+
Childhood Lead	\neg	_	-																							_	_	+
Health Ed/H. Prom.																											_	+
Adult Health/Pri. Care										1 2																		_
Child Health	_		$\overline{}$																									_
CC4C																												_
Children's Spcial Needs						1 1				3 3			. 0	3 3														_
Communicable Disease														3														_
AIDS/HIV	\neg																											
STD					18 18																							_
TB						1 3			3 Ja				()	9 9														-
Immunizations																												-
Prep & Response																												_
Comm. & Risk																		3 3										
Small Pox																		3 7										
Strat. Nat. Stockpile																												
Family Planning	15 0.																											
TANF									8 8												8 11	S - S						
Maternal Health																												
PCM																												
WIC - Administration									8 8								1 1								8			
WIC - Breastfeeding																												
WIC - Client Services																												
WIC - Nutri Education																												
WIC - BFPC	+	-																										
TOTAL HOURS 0.	00 0.0	0 0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CATEGORY - DATE 1	2		4	5	6	7	8	9	10	11	12		14	15	16	17	18	19	20	21		23	24	25	26		28	

EARNED COMP TIME / FLEX TIME:

SICK LEAVE

PETTY LEAVE

COMPTIME/FLEX*

Brought Forward: 0.00
CT Earned This Month: x1.5 0.00
Straight CT/Flex Earned This Month:
Less Comp./Flex Hrs. Taken This Month:
Comp/Flex Hrs. Carried Forward: 0.00
(Must match accumulative leave balance)

SUPERVISOR'S CT APPROVAL: __

*Comp Time is earned by non-exempt employees with prior approval from their supervisor have completed a 40 hr. work week. Flex Time is earned by exempt employees with prior a from their supervisor.

0

0

0

0

Approval of Health Director: _____

WIRM Expenditure Report Preparation

WIRM

- Web Identity Role Management
- Draw Down State Funding
- Report Local Allocations
- Completed Monthly
- Deadlines set by State Controllers Office
- Approved by Health Director
- Certified by County Finance Officer

Preparing for The WIRM Expenditure Report:

- County Finance General Ledger Expenditure Report
- Time Equivalency Report
- Monthly Revenue Sources
 - Medicaid earnings by program
 - Patient Fees collected for all programs
 - ■Insurance earnings by program
 - Grant or Other funding

Drawing down State Money

- Refer to your Agreement Addendum
- Required Work Activity
- Funding Stipulations
- Prior Approval for Purchases
- Limitation on monthly draw down amount
- Draw down by method other than expenditures

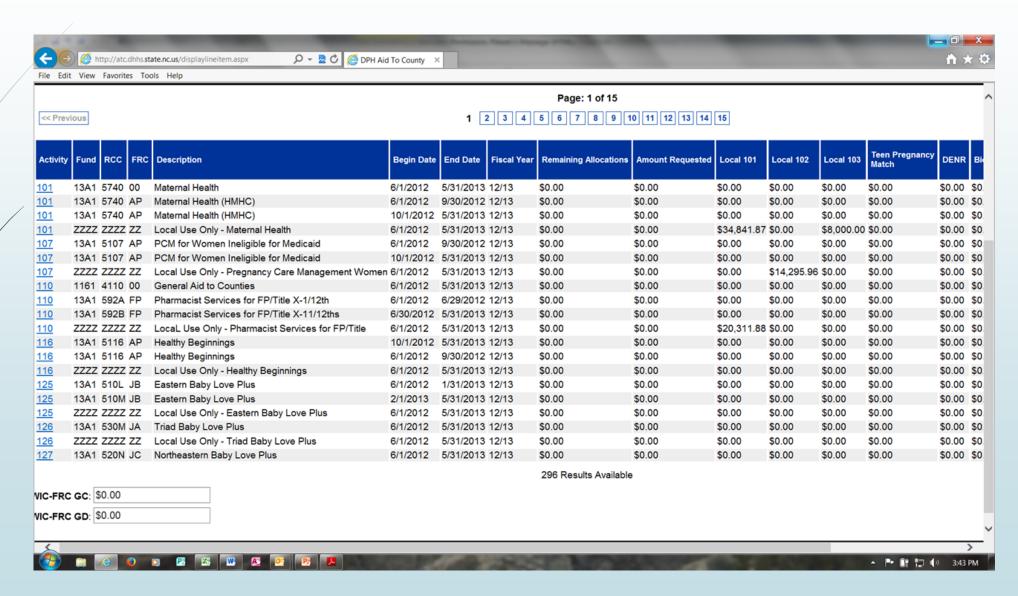
Checks and Balances

- Total County General Ledger Report for month should balance to the WIRM report for the month
- Program audits to ensure proper draw down of state funds
- Administrative Monitoring to ensure proper method for calculating WIRM

WIRM Login Screenshot



WIRM Line Screenshot



WIRM Totals for the Month

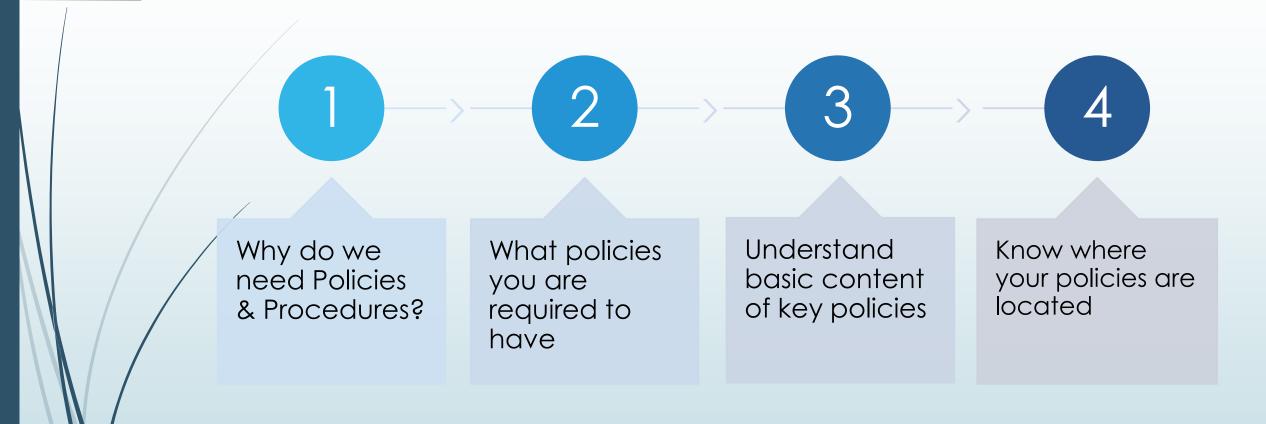
	Totals for the Month
Requested:	\$46,587.37
Loc 101:	\$145,236.45
Loc 102:	\$25,425.54
Loc 103:	\$7,483.25
Teen Pregnancy:	\$0.00
DENR:	\$0.00
Bioterrorism:	\$0.00
Temporary Food Establishment Fees:	\$0.00
Grand Total:	\$224,732.61

QUESTIONS

Policy & Procedure Development

Presented by Kathy Brooks
Public Health Administrative Consultant
DHHS/DPH/LTAT

Training Objectives



Why do we need Policies & Procedures?

- Roadmap for performing tasks and functions
- Provides consistency and structure
- Reference for staff
- Include required components (i.e. legal and statutory requirements)

What policies should we have?

- Policy on Policies/Formulation of **Policies**
- ► Fee & Eligibility (include) billing steps)
- Fiscal (administrative/division of duties)
- → Money handling/deposit → Personnel
- ► Fee Policy (what methods you use to set fees and how you implement)

- Medical Records (EHR)
- Scanning & Disposition of paper records
- HIPAA
- Bad Debt Write Off/Debt Set Off
- Title VI

Use this link for a complete list of Policies & Procedures required for Re-Accreditation

https://nciph.sph.unc.edu/accred/health_depts/materials/PolProcPlansreqbyHDSAI6-2-09.pdf

Policy on Policies/ Formulation of Policies:

- **■** Goal
- Purpose
- Definitions
- References
- Scope/Focus Population
- **■** Policy
- Service Plan/Plan
- Appendices

Fee & Eligibility Policy

- To ensure that all clients who wish to receive services are treated equally
- Needs to be clear and easily interpreted
- Identification (what forms are accepted)
- Economic Unit (what defines it)
- Determining Gross Income (what can you use)
- Sliding scale
- Fee Collection Medicaid, third party payers, patient pay (billing & follow up)
- Eligibility requirements by program (financial and residency)
- NC Public Health: For Local Health Departments (http://publichealth.nc.gov/lhd/)

Fiscal Policy

- Ensure that financial policies and procedures are consistent with The Local Government Finance Act, County Fiscal Guidelines, and the Consolidated Agreement
- Identifies who presents, approves and manages budget
- Ensure that there are checks and balances in place
- Records kept up to date and ready for audit
- Reports are timely and accurate

Money handling/deposits

- Procedure for every day money handling
- Segregation of financial management duties and accountability for funds
- Preparation of deposits (when & by whom)

Fee setting Policy

- To ensure accuracy, consistency and standardization in the development of fees
- Formulation, approval, and execution of establishing new fees for new services, and new fees for existing services.
- What method is used to set fees:
 - Medicaid Cost Report
 - Cost of providing the service
- Steps to approval
- Updating fee schedule (internally)

Medical Records Policy

- To create and maintain an accurate and complete medical or client records of services provided to an individual; to facilitate coordination of services and communication; to meet legal requirements
- Records handling
- Chart order
- Required forms
- Release of Information
- Purging, scanning, retention
- Use Records and Retention guidelines

Records Retention & Disposition http://archives.ncdcr.gov/Portals/3/PDF/schedules/Local%20Schedules/Local_Health_Departmens_20070907t.pdf?ver=2016
-03-11-084038-573

HIPAA Policies

- Provide requirements applicable to specified departments/divisions for protecting the privacy of individually identifiable health information.
- Confidentiality & Release of Information
- Authorization Policy

HIPAA Policies

- Minimum Necessary Policy
- Privacy Protections Policy
- Workforce Policy
- ■Security of PHI
- Notice of Privacy Practices
- Electronic Medical Records-Scanning & Maintenance

Bad Debt Write-off/ Debt Set-off Policies

- Establish a mechanism to age and account for uncollectable debt
- What is considered bad debt
- How is bad debt handled/what is the process
- How often is bad debt written off
- Who approves the write off
- If you use Debt Set-off, must have policies & procedures

Title VI - also referred to as (Limited English Proficiency/Compliance)

Ensure compliance with Title VI of the Civil Rights Act of 1964, and other applicable federal and state laws and their implementing regulations. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on the grounds of race, color or national origin by any entity receiving federal financial assistance.

Title VI

- Access to and utilization of interpreters
- Signage and assistance for hearing & visually impaired
- Translation of documents
- Who is your Compliance Officer position needs to be identified in your Title VI policy
- Handling complaints

Personnel

- Equal employment opportunity
- Affirmative action
- Local classification & salary range
- Recruitment and selection process
- Adhere to state personnel policies (GS 126 and 1 NCAC 8) or local policies if you are a Consolidated Agency

Where are your policies kept?

- Hard copy or electronic (or both)
- Master book shelf
- Shared drive
- In your workspace

QUESTIONS

Administrative Monitoring

Presented By Dianne Edwards
Public Health Administrative Consultant
DHHS/DPH/LTAT

Administrative Monitoring

Administrative Monitoring was developed to assure that Local Health departments are in compliance with the Consolidated Agreement, State Program Rules, Title X Requirements, and Local Policies.

Programs Reviewed

The following programs are reviewed as a part of Administrative Monitoring

- Maternal Health
- Child Health
- Family Planning
- STD
- **■** TB
- Immunizations

Areas Reviewed During Administrative Monitoring

- Staff Time Documentation
- Expenditure Reporting
- Budgeting
- o Revenue Management
- Patient Fee & Eligibility Policies
- Patient Financial Eligibility Screening
- Medicaid Eligibility
- Residency Requirements
- Accounts Receivable

WHSF and TANF Review

- Expenditure of the total allocation of Women's Health Service Funds and Temporary Assistance for Needy Families are now verified
- Invoices must be available to support all expenditures for both activities for the fiscal year in review
- Expenditures reported in the WIRM are reviewed to determine accuracy
- Expenditures have to be reported in the month the invoice was paid
 - Ex- order placed in October and invoice received in November. The bill was paid in December.
 - ■The expense is reported in the January WIRM for the December expense

WHSF and TANF Requirements

- WHSF must be expended for the purchase of Long Acting Reversible Contraceptives
- Funds are to be used for non Medicaid clients
- TANF funds must be used for the purpose specified in the program Agreement Addenda

Changes in Monitoring

- Completion of the Financial Checklist
- Review of Policies and Procedures for processing Denied claims
- ► Fees for 340B contract purchases are reviewed
- Review of Billing and Coding Process
- Review of Medicaid billing process and management of denials

DPH Financial Checklist

- Additional review tool which is now a part of Administrative Monitoring
- County Finance Office maintains many of the policies required for review
- District Health Departments are responsible since they are a separate entity
- Findings related to the Financial Checklist are considered funding conditions and may require a corrective action plan

DPH Financial Checklist Requirements

- Contracts (Consolidated Agreement)
- Budgets
- Accounting Procedures
- Purchasing Policies and Procedures
- Internal Control Policies
- Cost Allocation
- Inventory System
- Staff Time Records & Allocation of Personnel Expense
- Expenditure Reporting and Support Documentation

Billing Policies and Procedures

Written policy should be in place addressing how denied claims are handled; who is responsible, time frame for processing, steps for processing claims that can be re-billed

► Fee Schedule should reflect 340B pricing, and policy should indicate how charges are applied for any drug/device purchased through a 340B contract

Monitoring Process

- Health Director is contacted by the Administrative
 Consultant 45 days in advance to schedule monitoring visit
- Administrative Consultant will then send letter to confirm monitoring visit
- Monitoring tools and a list of documents needed for review will be sent with the confirmation letter
- Administrative Consultant will complete review on date scheduled

Monitoring Results

Findings are in one of two categories:

- Recommendations: Usually are issues identified that are considered to Best Practice. It is suggested that any recommendations be used to make changes to policies or procedures. No written response is required to address Recommendations
- Funding Conditions: Are any non compliance issues identified related to State or Federal program rules. A written Corrective Action Plan is required to address all Funding Conditions

Monitoring Process

- Findings will be discussed with Health Department staff in exit meeting
- A Monitoring Report will be submitted within 30 days of the review, to Central Office Staff in Raleigh
- After Monitoring Report is received, Health Department will have 30 days to complete Corrective Action Plan to address Funding Conditions
- Health Department will be notified within 30 days of submitting Corrective Action Plan if the plan is acceptable

Frequency and Exceptions

- Local Health Departments are selected for monitoring based when the Women's and Children's Health Reviews are done
- Administrative Monitoring is done in each LHD on a two year cycle

Exceptions to Monitoring Schedule

Local Health Departments can be monitored more frequently than the two year cycle if either situation occurs

- If State Program Staff make a specific request for a Local Health Department to be monitored
- Problems are identified during monitoring and not resolved through the implementation of a corrective action plan

Common Monitoring Findings

- Incomplete Fee and Eligibility Policies
- Policies do not state who will be served in each program (i.e. age, county resident)
- Statement "no one will be denied services due to inability to pay" is omitted
- For purposes of Family Planning, financial eligibility screening the statement "Minors and other individuals requesting confidential services are considered a family of one" is omitted
- WHSF and TANF funds reported incorrectly
- Policy does not include a description of reasonable billing efforts
- Bad Debt Write Off Policy not in policy
- Bad Debt Write Off Policy included in policy, but not being followed
- Patient Fee and Eligibility Policy not being reviewed on an annual basis
- Financial Eligibilities not competed correctly-missing signatures, incomplete documentation

Billing Review

- Billing Review is conducted by Administrative Consultant at the time Coding Audit is done by Nursing Consultant
- Financial Eligibility Screening
- Entry of Encounter into Billing System
- Fees were charged to clients according to the sliding fee scale
- Claims are billed to Medicaid and other third party payers
- Denied claims are rebilled

QUESTIONS

Training Evaluation Survey

Thank you for attending today's training.

We always want to be sure that we are meeting your needs and ask that you take the Training Evaluation Survey located at:

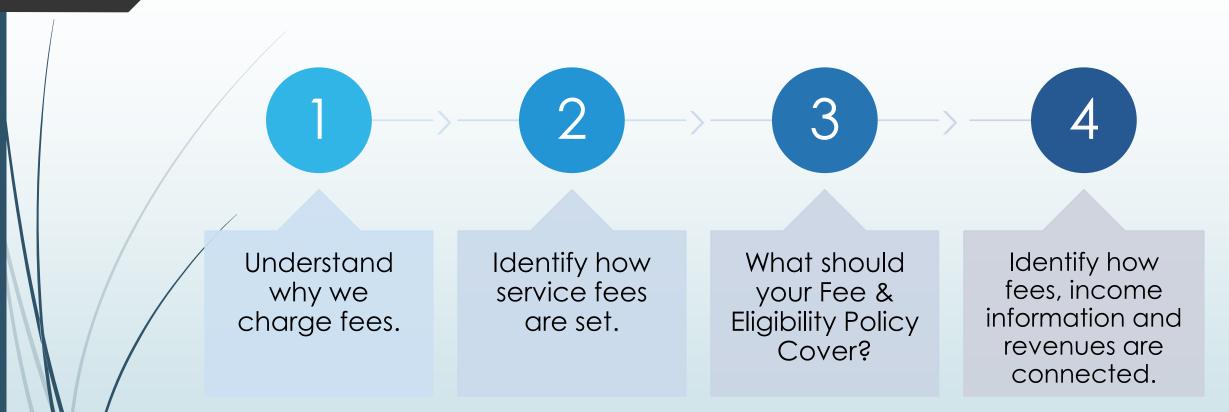
https://www.surveymonkey.com/r/ZC52GJK

Lunch Break We will start back at 1:30.

Fees, Eligibility, Billing & Reimbursement

Presented by Kathy Brooks
Public Health Administrative Consultant
DHHS/DPH/LTAT

Training Objectives



\$\$\$\$ Fee Setting \$\$\$\$\$

Why do we charge fees?

The purpose of charging fees is to increase resources and use them to meet residents' needs in a fair and balanced way. Fees are necessary to help cover the full cost of providing recommended and needed health services. As much as possible, we set fee amounts based on the real cost of providing that service (calculated as direct costs plus indirect costs).

North Carolina law¹ allows a local health department to charge fees for services as long as:

- 1. Service fees are based on a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners.
- 2. The health department does not provide the service as an agent of the State (i.e. VFC immunizations)
- 3. And the fees are not against the law in any way.

¹ North Carolina General Statute 130A-39(g)

What contributes to cost?

Direct Costs may include:

- Salary and fringe -typically 75-80% of budget (or more)
- Supplies- band aids, table paper, forms, syringes, alcohol wipes, etc.
- Pharmaceuticals
- Travel
- Computer hardware & software

Indirect Costs may include:

Facility costs (utilities, rent, insurance, cleaning contracts, etc)

How do we set fees?

- Health Department fees should be set based on the cost to provide the service. There is updated language in the Consolidated Agreement that states you may use "cost related" methods. This includes the Medicaid Cost Report.
- Methodology for setting fees is a required piece of evidence for reaccreditation. This should include any minutes from meetings held during the process. (Accreditation Activity 33.5)

Flat Fee Services

- Also determined based on the cost to provide the service
- No Sliding Fee Scale required
- Typically collected prior to service
- Child Health-Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service, if that service is partly or wholly supported by Title V funds. For clients having incomes above the federal poverty level, the sliding fee scale of the local health department will be used to determine the percent of client participation in the cost of the service.

Billing & Reimbursement

Billing & Reimbursement

Sample County Health Department Medicaid Billing & Reimbursement Jan – December 2016

Program	Total Services	Billed	Payments	Adjustments
AH	246	\$20,628.53	\$16,638.08	\$4,571.70
СН	748	\$48,283.08	\$46,685.59	\$1,582.49
FP	430	\$54,757.94	\$42,992.95	\$11,785.74
IM	313	\$31,563.85	\$24,462.91	\$6,296.82
MH	1,196	\$268,313.93	\$220,086.10	\$29,212.17
ST	412	\$68,604.41	\$54,192.07	\$13,294.03
ТВ	4	\$926.33	\$738.06	\$185.27
		\$493,078.07	\$405,795.76	\$66,928.12

Sample County Health Department Self-Pay Billing & Reimbursement Nov 2013 – June 2014

PRGM	SVC FEES	AMT ADJUSTED	BILLED	RECEIVED
AH	1,613.72	1,566.70	47.02	-
СН	60.00	60.00	1	-
FP	637,263.85	599,717.63	37,546.22	10,768.22
НС	56.30	56.30	-	-
IM	86,704.75	71,600.96	15,103.79	10,972.67
МН	233,611.94	211,249.16	22,362.78	4,744.08
OS	115.75	77.66	38.09	5.75
ST	293,967.08	293,190.42	776.66	-
ТВ	92,962.36	91,551.56	1,410.80	24.00
TOTAL	1,414,322.39	1,333,164.40	81,157.99	27,578.88

How do we collect the information we need?

Follow The Policies

- Scheduling Appointments
- Residency Requirements
- Method of Collecting Income Information
- Proof or Declaration of Income
- Formula for Calculating Income
- Sliding Fee Scale
- Applying Fees Based on % of pay

Fee & Eligibility Policy: Key Elements

- Must follow your agency Policy on Policies format
- Identification
- Proof of Residency
- Documentation of Income
- Determining Gross Income & Family Size
- Program Specific Eligibility Guidelines
- Billing & Revenue
 - Direct Patient Charges
 - Billing Medicaid and Insurance
- Fee Collection

Sample Fee & Eligibility Policy

- Located on the DPH/LHD website http://publichealth.nc.gov/lhd/
 - Template for your convenience
 - Includes all components to meet Administrative Monitoring requirements
 - If you use this be sure to change anything in RED font to reflect your own agency information.

Elements of Registration

- Name
- Alias (if applicable)
- Address (PO & Street)
- Phone
- Race & ethnicity
- Employer
- Medicaid/insurance, income documentation
- Household contacts & income
- Identification
- Signatures (Clerk & Client)

Residency Requirements

Must serve anyone requesting services regardless of what county they live in for:

Family Planning

Communicable Disease

Immunizations

Local Policy For Residency

■ It is a local policy decision as to whether or not you serve non county residents for

Adult Health

Maternal Health

Child Health

Proof of Identification

A copy of the proof of identification may be placed in the medical record dated with the date obtained and initials of clerk.

If no proof of identity is available due to theft, loss, or disaster, an individual is homeless, or a migrant, document the reason for no proof on the Patient Registration.

Proof of Identification

continued

- If the client refuses to provide picture ID for immunization, pregnancy prevention, sexually transmitted disease and communicable disease services then you may not require that they do SO. Effective July 1, 2011 as per Consolidated Agreement.
- Document any "alias" names that the client may present with

Proof of Identification continued

Name changes should not be made unless proper ID with corrected name is presented, i.e. social security card, driver's license, official ID with photo, birth certificate (children only).

Race & Ethnicity

Race Standards (Census.gov)

Based on Self-identification: White, Black or African American, American Indian or Alaska Native, Asian, or other Pacific Islander

■ Ethnicity: Ethnicity is a variable commonly used in studies on health disparities. Ethnicity is broken into two categories: Hispanic/Latino or Not Hispanic/Latino.

NOTE: Patients who do not complete the Race/Ethnicity section on the registration form will be asked by registration staff to complete the Race/Ethnicity section or to decline to self-identify. This will be marked in the patient's demographic screen.

Sliding Fee Scales

- Provided by DHHS and updated annually
- Based on Federal Poverty Register
- ► FP requires 101%-250% scale be used
- CH and MH is local decision

■ BCCCP requires 101%-250% scale be used

Collection of Revenue

Consolidated Agreement item 8. states:

For Departments participating in Medicaid Reimbursement, the Department shall:

a. Execute a Provider Participation
Agreement

with the Division of Medical Assistance.

Collection of Revenue

continued

b. Make every reasonable effort to collect its cost in providing services, for which Medicaid reimbursement is sought, through public or private third party payers except where prohibited by Federal regulations or State law; however, no one shall be refused services solely because of an inability to pay

Collection of Revenue continued

c. Establish one charge per clinical/support service for all payers (including Medicaid) based on their costs. All payers must be billed the same established charge, but the Department may accept negotiated or other agreed upon lower amounts (e.g., the Medicaid reimbursement rate) as payment in full.

Collection of Revenue

continued

d. There is an exception to the "one charge per service" and that is for 340B drugs.

Non-340-B Drugs

■ Providers shall bill their usual and customary charges.

340-B Drugs

■The PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the OPA at

http://opanet.hrsa.gov/opa/CE/CEMedicaidextract.aspx.

Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.

Collection of Revenue

continued

e. In extreme or unusual circumstances, the Health Director (or designee), in consultation with billing staff, is authorized to circumvent these guidelines.

Definition of Economic Unit

A family is defined as a group of related or non-related individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related.

Important Facts in determining Economic Unit

- Individuals can be related or not related
- → Must live in same household
- Household can consist of one or more economic units
- Relationship of individuals, who earns income, and consumption of goods determines who is included in screening

Questions to Ask

- Who lives at the same address
- Number of people employed
- How does each wage earner contribute to household expenses; and
- How does their income support the unit

Counting Family Members

- Pregnant woman can be counted as two by counting the unborn child
- Woman pregnant with twins can be counted as family of three
- Pregnancy must be confirmed to count unborn child/children

Family Planning Rules

- Anyone requesting confidential services must have fees assessed based on their own income.
- Age is not an issue when determining confidentiality
- Count as family unit of one
- Document "No Mail" client

Financial Eligibility Documentation of Income

Failure to bring proof of income or Third Party Confirmation Letter will result in the individual being charged 100%. Charges will remain at 100% if proof of income is not presented within 30 days (or another timeframe)

Financial Eligibility continued

Flat Fee services do not require financial eligibility

■ It is recommended that household income be checked on all patients including Medicaid eligible patients (in case there are non-Medicaid eligible services or the client eligibility cannot be confirmed).

Financial Eligibility Form

- Number in household
- Person/s employed
- Annual Income
- Percentage of Pay
- Signature of Interviewer
- Signature of Patient or parent/guardian
- Date of Eligibility Screening

In general, gross income includes (but is not limited to):

- Salaries, wages, commissions, fees, tips, overtime pay
- Earnings from self-employment (Net income after business expenses)
 Investment income, stocks, bonds savings account interest
- Periodic trust fund payments
- Public Assistance Moneys
- Unemployment compensation
- Alimony
- Military allotments including re-enlistment bonuses, jump pay, uniform allowance, and cash allowances such as Family Subsistence Supplemental Allowance (FSSA).
- Social Security benefits
- Supplemental Security Income (SSI)
- Veteran's Administration benefits
- Retirement and pension payments
- Workers Compensation
- Child Support Payments (except for FP)
- Stipends
- All other sources of cash income except those specifically excluded.
- Regular contributions from individuals not living in the household.
- Prize winnings, Christmas bonuses.

Exceptions: Gross Family income does not include those noncash income or payment/benefits from federal programs/acts including:

- Military housing benefits (on base or off base)
- Value of in-kind benefits
- Reimbursement from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Payment to volunteers under Title I (VISTA) and Title II (RSVP), foster grandparents, and others of Domestic Volunteer Service Act of 1973
- Payment under the Low Income Energy Assistance Act
- Scholarships
- Value of any child care payments made under section 402(g)(1)(E) Social Security Act
- Assistance to child or families for Free Lunch and Food Stamps

Frequency of Financial Eligibility Screening

- Financial Eligibility is good for one year unless changes in employment or income occur
- Ask at each visit if there have been changes
- If changes have occurred update the eligibility screening

Frequency of Financial Eligibility Screening

continued

- If no changes have occurred since previous screening, then no action is necessary unless 12 months have passed since last screening (indicate "no change", sign and date)
- May use reported income through other programs offered in the agency rather than re-verify income (within the 12 months)

Presumptive Eligibility (for Pregnant Women)

Effective for applications taken on or after August 15, 2014, pregnant women applying for presumptive eligibility are no longer required to attest to U.S. citizenship or eligible immigration status.

➤ Use new guidelines for applications taken on or after August 15, 2014.

continued

In order for a pregnant woman to be authorized presumptively she must:

- A. Attest to pregnancy.
- B. Attest to North Carolina residency or intent to reside in North Carolina.
- C. Not be an inmate of public institution.
- D. Not be receiving Medicaid in another aid/program category, county, or state.

continued

- E. Have household gross income equal to or less than 196% of the federal poverty levels listed in IV.F of Administrative Letter 06-13. The unborn(s) is included in the family size and the amount of household income is based on the pregnant woman's statement.
- F. Presumptive eligibility is limited to one presumptive period per pregnancy.

ri				

Patient Record # Date Care Initiated				N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE VE ELIGIBILITY DETERMINATION FORM FOR PREGNANCY – RELA								Eligible Ineligible Due Date		
		PRESUMI ddressStreet Addi		ILIT		ETER.							iil	
House	hold Members: HOUSEHOLD MEMBE	oc .							TAX FILING S	PATTIC				
Line No.	NAME (First, MI, Last)	DATE OF BIRTH (mm/dd/yyyy)	RELATIONSHIP TO APPLICANT	SEX	RACE* (optional)	ETHNICITY** (optional)	SOCIAL SECURITY # (optional)	NC RESIDENT? (y/n)	Will this person file federal income taxes for current year?	Claimed as tax dependent on current year's tax return? (y/n)	If tax dependent , who will claim?	Meet any tax exceptions?	Claim anyone not living in home? If so, who?	
1														
2	UNBORN CHILD													
3														
4														
5														
**Not Hispanic/Latino = N Hispanic Cuban = C Financial Eligibility Information: TOTAL COUNTABLE MONTHLY INCOME = \$ Health Insurance Information (optional):						Mexican	USEHOLD:	panic Puerto Ri	an = P Hispanic Other - H POVERTY INCOME LEVEL: \$					
Company Name Policy Holder's Name		Holder's Name	Policy Number			ımber	Group Number		Insurance Type(s))	Policy Begin Date		
and ac	curate information about eral government requires the	my household, ir	ncome, and state res	idency	y .								icaid by the last day of the y that I have provided true)	
Provider Name/NPI # Completed by (prin				nt):	nt): Title				Signat			ture/Date		
DMA.	-5032 (revised 7/2014)											Page 1 of 2	

Presumptive Eligibility

continued

Please make sure that completion of presumptive eligibility determination and referral for Medicaid eligibility determination is completed as early as possible for women accessing prenatal care services regardless of where they are opting to receive care. The timing for applying for presumptive eligibility must be early in pregnancy. Not necessarily at the "positive" pregnancy test, but within the 1st trimester.

excerpt from WHB Winter 2016 Report

Presumptive Eligibility

continued

■ As a reminder the health department is responsible for "collecting" the information that is needed to complete the presumptive application. They are not responsible for "verifying" the applicant's information. The verification of the presumptive application and decision to assign Medicaid for Pregnant Women (MPW)/ Medicaid lies with your local Department of Social Services.

excerpt from WHB Winter 2016 Report

Regulations & Resources

- ► Local Fee and Eligibility Policy
- Consolidated Agreement
- Medicaid Participation Agreement
- Program Rules and Regulations
- NC General Statues
- Administrative Consultants

Payment Schedules, Arrangement for Payments and Service Restrictions and Denials

Presented by Jessica Garner
Public Health Administrative Consultant
DHHS/DPH/LTAT

Changes in Public Health

- Reduced Grant Funds
- Reduced Medicaid Earnings
- Decline in Numbers of Services Provided
- Higher Costs Associated with Provision of Services

This results in...

- Loss of Positions
- Limited Resources
- Elimination of non-essential services

How Can We Increase our Revenue?

- Client Education
- Establish Expectations for Payment
- Explain the Need for Payment
- Develop a Payment Plan
- Follow Billing Policies
- Send Statements on a Regular Basis
- Credit/Debit Cards

Quality Assurance Involving Management Support Staff

Support Staff need to be a part of QA

Financial Eligibility Screening

Implementation of Fees

Billing

Follow-Up

Collecting Third Party Information

- Obtain Medicaid information and copy "card"
- Ask about other third party coverage
- Make copies of any insurance cards
- Collect any co-pay at the time service is delivered
 - Remember! Family Planning patients cannot be charged more in copays and deductibles than what they would pay based on SFS

General Billing Information

Medicaid is billed as the payer of last resort. Verification that patient is covered by Medicaid should be done at or before each visit. The health department bills Medicaid and accepts payment in full

General Billing Information

- You can bill client for Non-Medicaid covered services, but, you must inform the client that they will be responsible PRIOR to the service being performed.
- If unable to determine Medicaid eligibility (not covered during period of service) then the client should be billed based on SFS.
- If the client presents for services that are billable to insurance (BCBS- Immunizations, MNT), obtain all information necessary to submit a claim.

CoPays

Medicaid

Charge copays for: Adult Health/Primary Care Adult Dental Adult Immunizations

Insurance

Collect copay on card IF you are in-network
Otherwise, no obligation to collect

Family Planning Special requirements

Collect copay or sliding fee scale-whichever is lowest

Service Restrictions

- Counties may restrict services to only county residents only for Maternity, Child Health, Dental, Primary Care/Adult Health
- Counties can restrict services to only a certain population i.e. prenatal care for women with no insurance only, or dental clinic for clients birth to 21.
 - Follow your local policy
- ► FP, Immunizations, TB, CD, STD/HIV services must be provided to all clients regardless of county of residence.

Service Denials

- Family Planning, Maternal Health and Child Health do not distinguish between an inability to pay and unwillingness to pay
 - Denying or restricting patient visits due to financial reasons in these programs is not allowable
 - Child Health Title V funds should be used to cover Non-Medicaid clients

QUESTIONS

Managing Outstanding Accounts Receivable

Presented by Ann Moore

Public Health Administrative Consultant

DHHS DPH Local Technical Assistance and Training

Training Objectives



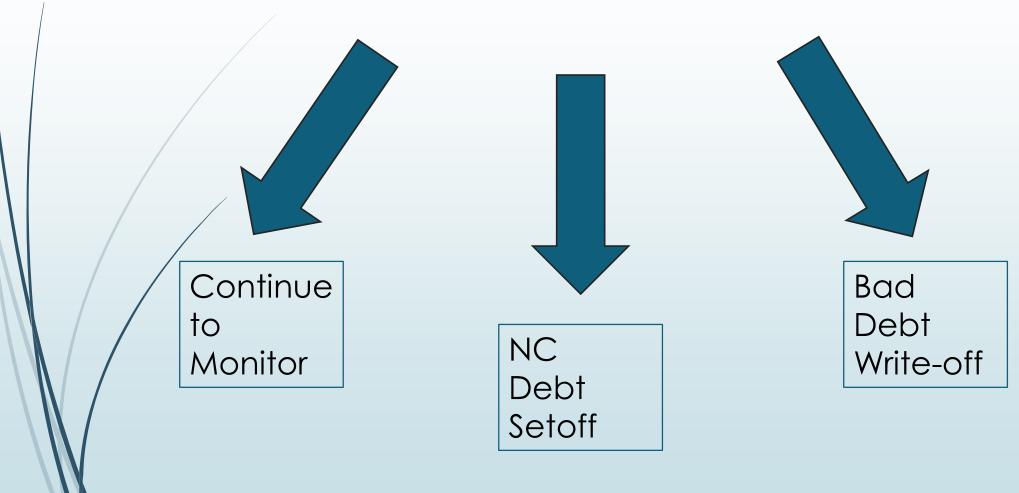
Bankruptcy

- Legal notification from Bankruptcy court
- No further collection of outstanding account
- Note or flag on patient's account
- Account may be written off
- Patient may volunteer to pay
- Additional visits are charged

Identifying Outstanding Accounts

- Aged Accounts Receivable Report
 - Medicaid
 - ■Insurance
 - Patient Pay
 - ■When was the last visit?
 - ■When was the last payment?

What are Our Options?



NC Debt Setoff

- North Carolina General Statutes Chapter 105A: Setoff Debt Collection Act
- NC Income Tax Refund or Lottery
- Mandated Fees
- Requires Name and SSN
 - Not a breach of confidentiality since debt is listed as county, not Health Department
- Requires Local Policy

Requirements for Debt Submission

- Debt Must be at least 90 Days Old
- Amount Must be at least \$50.00
- Must Give Proper Notice of the Debt to the Debtor
- Must Give Rights of Appeal to Debtor
- http://www.ncsetoff.org

NC Debt Setoff

- Debt Can Remain on File with NC DOR Until Paid
- Balances are NOT REMOVED from the Patient's Ledger
- Transfer the Balance to NC Debt Setoff Guarantor

Bad Debt Write-off

- Per Agency Written Policy
 - ► How old \$
 - How often?
 - Who approves?
- Removed from Ledger after Approval
- Patient is Never Informed of Bad Debt Write-off
- No Longer a Requirement to Reinstate Debt

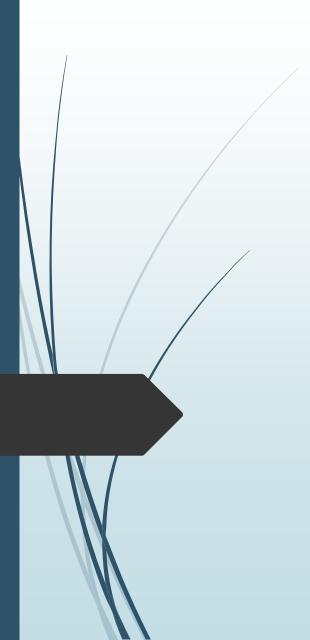
NC Debt Setoff

- Leave on Ledger
- Patient Notified
- 90 Days Old

Requires WrittenPolicy

Bad Debt Write-off

- Remove from Ledger
- Patient Not Notified
- Age According to Policy
- Requires Written Policy



Rules & Regulations

Presented by Dianne Edwards
Public Health Administrative Consultant
DHHS/DPH/LTAT

Rules To Follow

- North Carolina General Statute 130A
- North Carolina Administrative Code
- Title X Regulations
- Program Rules
- Consolidated Agreement
- Local Policies & Procedures

Rules

- NC GS 130A-39 (g) defines how fees may be charged
- Fees cannot be charged for services if prohibited by law
- Fees must be cost related
- Fees are recommended by the Health Director and approved by the Board of Health and County Commissioners

Standards for Local Health Department

- 10A NCAC 46.0201 lists the mandated services required to be provided in every county of this state. The local health department shall provide or ensure the provision of these services.
- Adult Health
- Home Health

Mandated Services

- Dental Public Health
- ► Food, Lodging & Institutional Sanitation
- Individual On-Site Wastewater Supply
- Sanitary Sewage Collection, Treatment & Disposal
- Grade A Milk Sanitation
- Communicable Disease Control

Mandated Services

- Vital Records Registration
- Maternal Health
- Child Health
- Family Planning
- Public Health Laboratory Support

Standards

The NC Administrative Code establishes standards for each service and a standard for quality assurance which applies to all mandated services. This is to insure that certain basic public health services would be available to citizens throughout the state and that each of these mandated services meets reasonable standards governing quality, availability and accessibility.

Child Health

- All fees charged to the patient are applied to the sliding fee scale
- Agency use whichever scale you want--101%-200%, 101%-250%, or you may go beyond 250%, but must slide to "0"
- Services cannot be denied to anyone at or below 100% of poverty

Child Health Requirements

➤ All third parties authorized or legally obligated to pay for services for those whose income level is at or below 100% (Medicaid or insurance) must be billed

Child Health Requirements

- Medicaid patients may not be denied services
- No one will be denied services based on an inability to pay
- Must have bad debt write-off policy
- Local fee policies must be adopted and approved by the Board of Health and County Commissioners

Family Planning

- Local Health Departments must charge fees for Family Planning services and charges must be applied to the sliding fee scale
- The use of the 101%-250% sliding fee scale is required and must slide to "0"
- Must serve individuals regardless of county of residence

- Minors and other individuals requesting confidential services must have fees assessed based on their own income
- The health department can use declaration or documentation to determine income, but the patient must be charged based on their declared income if documentation is not presented at the time of the visit

- No one can be denied service based on an inability to pay or because they have an outstanding balance
- ► Family size is determined by using the economic unit

- Must bill all public or private third party payers
- Family Planning patients cannot be required to pay in advance
- Emergency services may never be denied
- Local fee policies must be adopted and approved by the Board of Health and County Commissioners

- ➤ You shall establish, implement and maintain written policies for the provision of community and client family planning education services 10A NCAC 46.0206
- Must have a bad debt write-off policy
- May charge for non-essential supplies or replacement cycles of pills but on a sliding fee scale

Maternal Health

- ➤ You can have a residency requirement for your clinic
- Any charges for services must be applied to the sliding fee scale and must slide to "0"
- ➤ You may use whichever sliding fee scale you want, 101%-200%, 101-250% or higher

Maternal Health Requirements

- Services cannot be denied once you have accepted a patient into you program because it then becomes abandonment
- You cannot deny services to anyone at or below 100% of poverty

Maternal Health Requirements

- You cannot deny services to Medicaid patients
- Patients cannot be required to pay for services in advance
- Must have a bad debt write-off policy

Maternal Health Requirements

- ➤ You shall establish, implement and maintain written policies for the provision of community and patient maternal health education services. Education services shall promote healthy lifestyles for good pregnancy outcomes 10A NCAC 46.0205
- Local fee policies must be adopted and approved by the Board of Health and County Commissioners

Adult Health

- You may have a residency requirement for this program
- You may charge a flat fee for services or may use a sliding fee scale that does not have to slide to "0"
- ► You may choose which sliding fee scale you want to use, 101%-200%, 101%-250% or any other scale

Adult Health Requirements

- If you bill Medicaid, you must bill insurance
- Services may not be denied based solely on an inability to pay
- You cannot deny services to Medicaid patients
- You must have a bad debt write-off policy

Adult Health Requirements

- ➤ You shall establish, implement and maintain written policies for the provision of cancer, diabetes and hypertension health education services 10A NCAC 46.0209
- Local fee policies must be approved and adopted by the Board of Health and County Commissioners

Dental Health

- Allowable to restrict services to county residents
- Not a requirement to see patients who have insurance, however some Medicaid patients also have insurance
- Medicaid is the payer of last resort
- You must see patients who are at or below 100% of poverty
- Restricting or denying services is based on local policies

Dental Health Requirements

- Fees can be applied to a sliding fee scale
- Charges don't have to slide to "0". There can be a minimum payment for services.
- You can choose which sliding fee scale to use
- You must have a bad debt write-off policy

Dental Health Requirements

- ➤ You cannot refuse to provide services to anyone below 100% of poverty who is unable to pay the minimum fee
- ➤ You shall establish, implement and maintain written policies for the provision of community and client dental public health education services 10A NCAC 46.0207

Dental Health Requirements

■ Local fee policies must be adopted and approved by the Board of Health and County Commissioners

Communicable Disease

- Policy cannot have a residency requirement for Communicable Disease
- Patients cannot be charged a fee for testing or treatment of Communicable Disease
- Medicaid and insurance can be billed for services provided
- Patients should sign a consent for billing insurance
- Patients should be informed that an EOB will be generated if insurance if billed

Communicable Disease Requirements

➤ You shall establish, implement and maintain written policies for the provision of communicable disease control education services 10A NCAC 46.0214

BCCCP

- Must see women who are at 250% of poverty or less, age 18-64 years of age with special emphasis on ethnic minority women age 50-64
- You will see patients who are uninsured or underinsured or those who are not funded by any other federally funded program (Medicare Part B, Medicaid or other)

BCCCP Requirements

- A residency requirement is allowed
- Agency may choose method of income collection
- There are two options:
 - **Economic Unit**
 - Purchase of Care Guidelines

BCCCP Requirements

- Only income that is earned (wages, tips, salary) and child support is counted
- Must have signed agreements with all providers

Consolidated Agreement

- Must follow requirements of Consolidated Agreement when developing policies
- Will not be covered in this presentation since it is a part of the Finance Training

QUESTIONS

Training Evaluation Survey

Thank you for attending today's training.

We always want to be sure that we are meeting your needs and ask that you take the Training Evaluation Survey located at:

https://www.surveymonkey.com/r/ZC52GJK